



**The Critical Illness Recovery Plan – Stroke claim package contains three parts:**

- Part A:** Critical Illness Recovery Plan – Stroke claim form
- Part B:** Attending Physician's Statement - Stroke
- Part C:** Additional Supporting Documentation

**Note:**

- Request for medical records excludes any genetic test results. Please do not provide any genetic test results.**
- Please print all information using a pen.**
- Initial all corrections/changes, including any changes you make with correction fluid (liquid paper).**
- Completion of all parts is required, and any missing information may result in a delay of the processing of your claim.**
- Checkboxes are provided below to assist you in completing the claim package.**
- A claims analyst will send you a confirmation of receipt in writing within 10 business days of receiving your claim package.**
- If you have any questions, please contact TD Life Insurance Company at 1-888-788.0839.**

**Check if completed:**

**Part A – Critical Illness Recovery Plan - Stroke Claim Form**

**Note: All sections in Part A** to be completed by the Insured Person with the critical illness or an authorized representative of the Insured Person with the critical illness.

- Section 1 – Policy Information**
- Section 2 – Insured Person's Statement.**
- Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)**
- Section 4 – Declaration, Authorization & Signature**

**Part B – Attending Physician's Statement – Stroke**

**Note: Part B** of this document can be detached and provided to the Attending Physician to complete and send separately to TD Life Insurance Company.

- Section 1 – Insured Person's Authorization**
  - The Insured Person's signature and date are required.
- Section 2 - Attending Physician's Statement**
  - Must be completed and signed by a licensed medical practitioner.

**Part C – Additional Supporting Documentation**

- Hospital Discharge Statement** – Please provide a copy, if available.
- Proof of Age of Insured Person** – Please provide a copy of one of the following:
  - Birth Certificate
  - Canadian Driver's License
  - Permanent Residence Card
  - Canadian Passport
  - Canadian Citizenship Card



**TD Insurance**  
TD Life Insurance Company  
P.O. Box 1  
TD Centre  
Toronto ON M5K 1A2

### Part A – Critical Illness – Stroke Claim Form

In this form "Insured Person" means the person who is insured under this policy.

#### Section 1: Policy Information

Critical Illness Recovery Plan insured by TD Life Insurance Company\*

<b>Policy Number</b>	
<b>Issue Date</b>	
<b>Name of Insured Person</b> (please print full legal name)	
<b>Policy Owner Name</b> (if different than Insured Person)	
<b>Type of Claim</b>	Critical Illness – Stroke

\*TD Life Insurance Company is the authorized administrator for this insurance. For more details on insurer and/or administrator information, please refer to the Insurance Policy.  
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**Section 2: Insured Person's Statement**

<b>Insured Person's Name:</b>	
<b>Insured Person's Address:</b>	
<b>Insured Person's Date of Birth:</b> (mm/dd/yyyy)	
<b>Insured Person's Contact Details:</b> <b>Residence/Cellular</b>	
<b>Insured Person's Email address:</b>	
<b>If a smoker, please provide the last date used</b>	<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker  Date:
<b>Please indicate type of tobacco product or use of any substance or product containing the following:</b>	<input type="checkbox"/> Tobacco <input type="checkbox"/> Nicotine <input type="checkbox"/> Marijuana
<b>Nature of Illness:</b>	
<b>Date illness or symptoms first appeared:</b> (mm/dd/yyyy)	
<b>On what date did the Insured Person first consult a doctor in connection with their illness?</b> (mm/dd/yyyy)	
<b>Has the Insured Person undergone any tests or investigations related to this diagnosis?</b> <b>If yes, please provide details and dates.</b> (mm/dd/yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> No  Details/Dates:
<b>Has the Insured Person previously suffered from or received treatment for a similar or related condition?</b>  <b>If yes, please provide dates and details.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No  Details/Dates:
<b>Please describe any residual neurological deficits</b>	
<b>Have any immediate family (mother, father, brothers, sisters) had heart disease, stroke, diabetes, cancer or tumour or kidney disease prior to age 60?</b>  <b>If yes, please list relationship, nature of illness, date of diagnosis and relationship.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No  Details:
<b>Date admitted to hospital:</b> (mm/dd/yyyy)	
<b>Date of release from hospital:</b> (mm/dd/yyyy)	
<b>Hospital Name:</b>	
<b>Hospital Address:</b>	

<b>Name of Family Physician:</b>	
<b>Address of Family Physician:</b>	
<b>If less than 2 years, please provide name &amp; address of previous physician(s).</b>	

**Additional Comments:**

### Section 3 – Electronic Funds Transfer Authorization (Direct Deposit)

If your claim payment is \$60,000 or less, at your request, we can deposit your benefit directly to your designated account. This will ensure that you receive your claim payment as quickly and efficiently as possible.

Do you wish to proceed with this option?  Yes  No

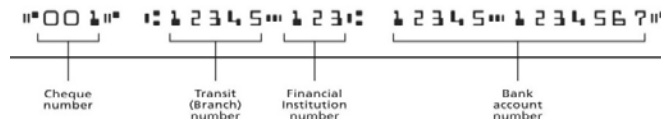
If Yes, please attach a void cheque that clearly identifies the Bank Account (the "Account") into which you wish the payment to be deposited into OR, enter this information in the space provided under **Account information** and sign and date this form at the bottom. Please note that if you are not a TD Canada Trust account holder and are not attaching a void cheque, we require your financial institution's address in order to deposit your benefit into your designated account.

Your account information can be verified by contacting your financial institution or by referencing the numbers at the bottom of your cheque:

**Branch Transit Number:** This is the 5-digit number that identifies your home banking branch

**Financial Institution Number:** Every Canadian Financial Institution has its own 3-digit number. For example, TD Canada Trust is 004

**Bank Account Number:** This is a unique 7-digit number that is used to refer to your personal account.



#### Account Information

\_\_\_\_\_

Branch Transit Number    Financial Institution Number    Bank Account Number

#### Bank Address

I \_\_\_\_\_ (please print name) as the Insured Person under the Insurance Policy (the "Insurance Contract"), issued by TD Life Insurance Company (TD Life), hereby irrevocably direct and authorize TD Life (both as insurer and as administrator to deposit all claim benefits payable under the Insurance Contract, through electronic funds transfer (direct deposit) to the account number as noted above and this shall serve as your good and sufficient authority for so doing. I consent to the collection, use and disclosure of my personal information for the purpose of paying this claim by this method. I fully release TD Life from any and all liability in regard to such payment upon its deposit in the above-described Account. If such account is a joint account with any other person or belongs to a third party, it shall not be TD Life responsibility should any funds be withdrawn by any person other than me or are used to pay down any indebtedness for which this account is responsible. I understand that TD Life is unable to verify the accuracy of an account number so I am responsible in the event that an incorrect account number is provided. I will ensure the information is accurate.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date (mm/dd/yyyy)

## Section 4: Declaration / Authorization / Signature

### Insurer: TD Life Insurance Company

- I declare that all the statements made in this claim form are accurate, true and complete. I understand that making false, misleading or incomplete statements may cause not only the claim to be denied, but insurance coverage to be void.
- By signing below, I agree that we may collect, use and disclose your Information as described in the Privacy Policy attached to my Insurance Policy including for, but not limited to, the purposes of identifying me, providing ongoing service, processing my claims, understanding my financial needs, protecting us both from fraud and error and complying with legal and regulatory requirements.
- I hereby authorize and request any physician, hospital, clinic, individual, law enforcement or government organization, insurance company, worker's compensation body, current or former employer, or other entity that has any personal and medical records, information or knowledge in regard to the Insured Person, to release and provide full details (including furnishing copies) of all available personal and medical information records and knowledge, including prior medical history, toxicological or pathological findings which they may possess to the above noted Insurer in regard to this claim, its re-insurers or their respective agents. This information is to be used in the evaluation of an insurance claim and for purposes relating to such claim.
- I also authorize the Insurer, its reinsurers and its respective agents to exchange and/or transmit information concerning this claim to the organizations listed above as is necessary to evaluate this claim. This consent shall be valid during the continuation of such claim.
- In providing this authorization to collect personal information about the Insured Person relating to this claim, I the undersigned do hereby certify that I have appropriate permission from the Insured Person to authorize the collection, use and disclosure of their personal information as authorized above and that the Insurer and its agents and reinsurers may rely and act upon my authorization.

### Insured Person

By signing below you—the insured person—also agree to the following unless you check the box below to indicate that you do not agree:

- If you do not qualify to claim for the Critical Illness Benefit, we may explain this to the Policy Owner. If other information negatively affects our claims decision, we may tell the Policy Owner whether the relevant information relates to your family history, medical information, or lifestyle.

I do not agree to the disclosure of my personal information to the Policy Owner.

Insured Person's Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Please print)

(mm/dd/yyyy)

Insured Person's Signature: \_\_\_\_\_

**A photocopy/fax of this authorization is as valid as the original.**



**TD Insurance**  
 TD Life Insurance Company  
 P.O. Box 1  
 TD Centre  
 Toronto ON M5K 1A2

**Part B – Attending Physician's Statement**

**Critical Illness - Stroke**

**Notes:**

- The Insured Person is responsible for securing this form and any charge which may be made for its completion.
- Request for medical records excludes any genetic test results. Please do not provide any genetic test results.

**Section 1: Insured Person's Authorization**

**Critical Illness Recovery Plan is insured by TD Life Insurance Company\***

<b>Policy Number</b>	
<b>Insured Person's Name</b> (please print)	
<b>Date of Birth</b> (mm/dd/yyyy)	

I hereby authorize the release to my insurer any information requested in respect of this claim to TD Life Insurance Company.

Signature of Insured Person: \_\_\_\_\_

Date \_\_\_\_\_  
 (mm/dd/yyyy)

\*TD Life Insurance Company is the authorized administrator for this insurance. For more details on insurer and/or administrator information, please refer to the Insurance Policy.  
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## Section 2 - Attending Physician's Statement (Completed by Physician)

- This form has been specifically designed with the Physician in mind. By being comprehensive, it will hopefully reduce the physician's administrative workload. Please complete the sections relating to your patient and strike out non-applicable areas. In order to help the Insured Person, sufficient details of family and medical history, investigation, findings and treatment are essential.
- This form may be mailed directly to TD Life Insurance Company or given to the Claimant at the physician's discretion.
- The above named is insured with TD Life Insurance Company against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with a **Stroke** and, to enable the assessment of the claim, we would appreciate for your cooperation on the completion of this form.

<b>Patient's Name:</b> (Please print)	
<b>Patient's Date of Birth:</b> (mm/dd/yyyy)	
<b>On what date did your patient first consult you for this condition?</b> (mm/dd/yyyy)	
<b>How long has the insured been your patient?</b>	
<b>Name and Address of Family Physician:</b>	
<b>Was a diagnosis of Cerebrovascular Accident made?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>On what date did the CVA occur?</b> (mm/dd/yyyy)	
<b>Please describe the cause of the CVA (if known).</b>	
<b>Please describe the residual neurological deficits.</b>	
<b>How long have the neurological deficits persisted?</b>	
<b>By whom was the diagnosis made (if other than yourself)?</b>	
<b>On what date was the patient advised of the diagnosis? By Whom?</b>	

(continued)



Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke or CVA.

Name of Physicians/Hospitals	Address

<p><b>Has your patient previously suffered from a previous stroke?</b> If "Yes", please provide dates and details.</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No Details:</p>
<p><b>Have any immediate family (mother, father, brothers, sisters) had heart disease, stroke, diabetes, cancer or tumour or kidney disease prior to age 60?</b> If yes, please provide details:</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No Details:</p>
<p><b>Is your patient a smoker?</b> If yes, please provide the year the patient started smoking and the last date used</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No Date started: Date last used:</p>
<p><b>Are you related to or in a business relationship with this patient?</b></p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>

Please provide copies of clinical notes and hospital reports for our Medical Director's review. The neurologist's recent assessment results. Please provide any other information to would be helpful in the assessment of your patients claim. Attach any specialist report, pathology or test results, if available. Please mail or fax this form to:

**TD Insurance**

Claims Department  
P.O. Box 1 TD Centre  
Toronto, Ontario M5K 1A2

**Tel: 1-888-788-0839**

Fax: 416-308-1223 / 1-877-838-2163

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**Declaration: These statements are true and complete to the best of my knowledge and belief.**

Physician's Name: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_  
(Please print)

Physician's Specialty: \_\_\_\_\_

Date: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Thank you for taking the time to complete this form.